No. 14-723

IN THE

Supreme Court of the United States

ROBERT MONTANILE,

Petitioner,

v.

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF *AMICUS CURIAE* OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS IN SUPPORT OF RESPONDENT

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BRIEF *AMICUS CURIAE* OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS IN SUPPORT OF RESPONDENT

The National Coordinating Committee for Multiemployer Plans ("NCCMP") is a nonprofit, tax exempt organization that has participated for over thirty years in the development of employee benefits legislation and regulations promulgated to implement the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, and other laws affecting multiemployer plans.[1] The NCCMP's primary purposes are to

[1] Pursuant to Rule 37.6 of the Rules of this Court, the undersigned hereby state that no counsel for Petitioner or Respondent

assure an environment in which multiemployer plans can continue their vital role in providing medical, pension, and other benefits to working men and women, and to participate in the development of sound employee benefits legislation, regulations, and policy.

The NCCMP is the only national organization devoted exclusively to protecting the interests of multiemployer plans by advocating on behalf of these plans in Congress, in the courts, and in the regulatory process. Multiemployer plans provide benefits to tens of millions of American workers. Hundreds of multiemployer plans and related organizations, with a nationwide participant base, are affiliated with the NCCMP. Affiliated plans are active in every segment of the multiemployer plan universe, including the airline, building and construction, entertainment, food production, distribution and retail sales, health care, hospitality, mining, maritime, industrial fabrication, service, textile, and trucking industries. Congress has recognized that the continued well-being and security of employees, retirees, and their dependents are directly impacted by multiemployer plans and that interference with the maintenance and growth of such plans is contrary to the national public interest. *See* 29 U.S.C. § 1001(a)(1), (3), (c)(2).

Because of the broad range of experience of the NCCMP's constituent organizations, the NCCMP believes it is uniquely qualified to state the position of the trustees of multiemployer plans and to offer special insight into the impact this case will have on the efficient administration of these plans. Moreover, while the

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authored any part of this brief. Moreover, no person or entity other than the NCCMP made a monetary contribution to the preparation or submission of this brief.

NCCMP participated as amicus in both *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006), and *US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013), the instant case is of special importance to the NCCMP because it involves a petitioner's effort to limit the scope of relief available to a fiduciary under § 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), where that fiduciary happens to be the board of trustees of a multiemployer plan.

The NCCMP and its constituent groups have a strong interest in supporting the decision below to ensure that multiemployer plans continue to have an effective, efficient, and uniform equitable remedy available to them in the federal courts to recover amounts due to the plans. More specifically, the NCCMP and its constituent groups have a strong interest in preserving the enforceability and effectiveness of self-funded multiemployer plans' subrogation and right of reimbursement provisions under § 502(a)(3) of ERISA, in accordance with the Court's decisions in *Sereboff* and *McCutchen*. Both Petitioner and Respondent have filed blanket consent to the filing of amicus curiae briefs in support of either party or of neither party.

INTRODUCTION

The decision below concerns the scope of § 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), which authorizes a civil action by ERISA plan fiduciaries "to enjoin any act or practice which violates . the terms of the plan, or . to obtain other appropriate relief to enforce the terms of the plan." To proceed under § 502(a)(3), plans must seek only "those categories of relief that were typically available in equity." *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 210 (2002) (quoting

Mertens v. Hewitt Assocs., 508 U.S. 248, 256 (1993)). Thus, an ERISA plan may seek recovery under § 502(a)(3) for its share of payments received from a responsible tortfeasor only if the plan's claim for relief is equitable.

In *Sereboff* this Court held that an ERISA plan could enforce its equitable claim to a portion of payments received from a third party when the terms of the plan create an equitable lien by agreement. The Court first determined that the nature of the relief sought was equitable because it sought a specific portion (the cost of the medical benefits it advanced) of specifically identified funds (the Sereboffs' settlement with the third party tortfeasor). 547 U.S. at 363-64. This Court then determined that the plan's reimbursement provision created an equitable lien by agreement, which forms a basis for appropriate "equitable relief" enforceable under § 502(a)(3) and Supreme Court precedent. *Id.* at 369. Relying on "the familiar rule of equity that a contract to convey a specific object even before it is acquired will make the contractor a trustee as soon as he gets title to the thing," Mid Atlantic could "follow a portion of the recovery into the Sereboffs' hands as soon as the settlement fund was identified." *Id.* at 364 (internal quotations omitted) (quoting *Barnes v. Alexander*, 232 U.S. 117, 121, 123 (1914)).

In *McCutchen*, the Court reinforced *Sereboff*'s treatment of equitable liens by agreement. Rejecting the ERISA plan participant's attempt to assert equitable defenses to defeat the plan's reimbursement provision, the Court explained that a lien by agreement "as its name announces – both arises from and serves to carry out a

contract's provisions" and that "enforcing the lien means holding the parties to their mutual promises." 133 S. Ct. at 1546 (internal citations omitted). "Conversely, it means declining to apply rules—even if they would be 'equitable' in a contract's absence—at odds with the parties' expressed commitments. . In those circumstances, hewing to the parties' exchange yields 'appropriate' as well as 'equitable' relief." *Id.* at 1546-47.

Sereboff and *McCutchen* are based on principles fundamental to ERISA and long recognized by this Court: attention to the terms of written plan documents and enforcement of those terms. *See, e.g., Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 555 U.S. 285, 300 (2009) (section 502 claims "stand[] or fall[] by the terms of the plan"); *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995) (ERISA's statutory scheme is "built around reliance on the face of written plan documents"); *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985) (ERISA's principal function is "to protect contractually defined benefits").

Accordingly, the majority of courts to consider the issue have held the parties to their bargain and enforced equitable liens by agreement, rejecting various attempts by participants and beneficiaries to evade their obligations. In *McCutchen*, for example, the Court held that an ERISA plan may recover medical expenses paid on behalf of a participant because of a third party's actions if the participant later recovers money from the third party, even if the participant's recovery did not make him whole. *See McCutchen*, 133 S. Ct. at 1547-48. And the majority of circuit courts to consider the dissipation issue this case presents have held, consistent with the

decision below, that an ERISA plan may enforce its claim to a portion of payments received by a third party even when the participant has spent those funds. *See AirTran Airways, Inc. v. Elem*, 767 F.3d 1192, 1198-99 (11th Cir. 2014) (collecting cases).

The case currently before the Court represents the latest attempt by a plan participant or beneficiary to avoid the agreement to which he or she is bound. Montanile contends that the Plan's right to enforce its valid equitable lien by agreement can be destroyed by his subsequent dissipation of settlement proceeds subject to the Plan's equitable lien. If adopted by this Court, Montanile's position would make an ERISA plan's reimbursement and subrogation provision unenforceable—effectively nullifying the provision—whenever a beneficiary dissipates the money he or she recovers from a tortfeasor, or would otherwise place significant administrative burdens on an ERISA plan whenever it seeks to enforce an equitable lien.

This disregard for plan terms would be devastating to multiemployer plans. Trustees of such plans heavily rely on ERISA's guarantee that plan terms will be enforced as written. Multiemployer plans are not profit-making entities. They are products of the collective bargaining process, and they serve as vehicles for providing health and retirement benefits for working men and women and their families. Often, the participants in multiemployer plans work in industries characterized by physically demanding work, such as construction and related trades and crafts, which lead to more medical claims than workers in other industries. The plans' survival is conditioned upon parties' ability to ne-

gotiate agreements that meet the wage and benefit requirements of workers while enabling their employers to remain profitable. This allows the employers involved to provide both jobs and the medical benefits that are the focus of this case.

Multiemployer plans are run by joint boards of trustees appointed by participating employers and labor organizations. Trustees are, therefore, acutely aware of the limited ways in which plans can keep up with ever-increasing health care costs: employers can contribute more money towards the plans, which may make the cost of their products or services less competitive in the market; employees can either assume a larger percentage of their health care costs through increased employee contribution rates or take cuts in pay to offset higher employer contribution rates; or plans may be forced to make cuts in benefits. These plans contain subrogation and reimbursement provisions to avoid double recovery by a single beneficiary at the expense of all other participants and beneficiaries. In a very real sense, when a participant refuses to honor these terms of the plan he deprives the remaining participants and beneficiaries of the medical benefits to which they are entitled.

Although *Sereboff* and *McCutchen* provide a narrow equitable right to reimbursement, they at least provide fiduciaries with access to the relief necessary to enforce plan terms by allowing plans to impose equitable liens by agreement. Petitioner's position, if upheld, will undermine that modest achievement by allowing a beneficiary to spend the recovery to which the plan is entitled, and then refuse to honor his

obligation to reimburse his benefit plan. The NCCMP submits this brief to urge the Court to affirm the decision below and leave to multiemployer plans the narrow, but critically important, equitable remedy under § 502(a)(3) of ERISA that is the equitable lien by agreement.

SUMMARY OF THE ARGUMENT

The Court of Appeals properly held that the National Elevator Industry Health Benefit Plan's claim under § 502(a)(3) of ERISA was permissible because it sought to enforce the terms of its plan through an equitable lien by agreement, which is enforceable even if the specifically identified funds are dissipated. Therefore, the lower court's decision should be affirmed. A multiemployer plan must be able to enforce its terms and obtain payments that rightfully belong to the plan. Otherwise, a single beneficiary's double recovery comes at the expense of all other plan participants and beneficiaries. The lower court's decision also has the effect of protecting valuable medical benefits provided to beneficiaries, which will be lost if plans do not retain an effective method to assert their equitable reimbursement rights. The narrow equitable remedy asserted by the National Elevator Industry Health Benefit Plan is crucial for benefit plans to recover overpayments in a wide range of contexts, and plans lack other effective remedies at the state and federal levels. Finally, the decision below is consistent with Congress's objectives in enacting ERISA to enforce plan terms, protect contractually defined benefits for *all* participants and beneficiaries, and preserve a uniform system for administering benefit plans.

ARGUMENT

I. IT IS CRUCIAL THAT MULTIEMPLOYER FUNDS RETAIN THE RIGHT OF REIMBURSEMENT FOR BENEFITS THAT THEY HAVE ADVANCED TO PARTICIPANTS AND BENEFICIARIES.

The outcome of this case will turn on whether ERISA plans' equitable liens by agreement may be enforced when the funds subject to such liens have been dissipated. The NCCMP agrees with and finds persuasive Respondent's analysis of the principles of equity and its conclusion that an ERISA plan's right to enforce a lien by agreement cannot be defeated by dissipation. In addition, there are numerous reasons – both practical and policy-oriented – that compel the NCCMP to advocate for this conclusion, which is necessary for the sound administration of the plans that the NCCMP represents and their continued ability to provide benefits under all circumstances.

A. Subrogation and Reimbursement Provisions in Multiemployer Plans Protect all Plan Participants and Beneficiaries.

Petitioner and its amici urge this Court to place the interests of an individual participant above the written plan document. This cannot be done without harming all other plan participants.

Participants and beneficiaries in self-funded plans of all types are directly impacted by the unenforceability of their plans' reimbursement and subrogation provisions. The United States, as amicus in *Sereboff*, and Petitioner's amicus American Association for Justice acknowledge that "an employer who self-insures di-

rectly reduces its costs by recovering those costs from a third-party." Brief for the United States as Amicus Curiae Supporting Respondent, *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356 (2006) (No. 05-260), 2006 WL 460876, at *26 n.10; *see also* Br. for Am. Ass'n for Justice as Amicus Curiae at 17 (for self-insured plans, reimbursements "will [] go directly into plan assets to reduce the fund's costs"). Without these recoveries and reimbursements, plans' increased costs must be borne by all other participants and beneficiaries.

The Eighth Circuit clearly described the consequences of failing to enforce subrogation and reimbursement plan provisions in *Administrative Committee of Wal-Mart Stores, Inc. Associates' Health & Welfare Plan v. Shank*, 500 F.3d 834 (8th Cir. 2007). In that case, the plan paid $469,216 in medical bills on behalf of a beneficiary, covering all of her medical expenses following an automobile accident. *Id.* at 835. When the beneficiary recovered $700,000 from the responsible tortfeasor, the plan asserted a lien by agreement of $469,216. *See id.* at 835-36. The beneficiary, who had placed the recovery in a special needs trust, argued that the plan's lien was not equitable and thus could not be enforced under § 502(a)(3). *See id.* at 836. In upholding the plan's right to enforce its reimbursement provision, the Eighth Circuit recognized that the interests of one participant cannot override the written plan document without harming all other plan participants.

> We acknowledge the difficulty of Shank's personal situation, but we believe the purposes of ERISA are best served by enforcing the Plan as written. Shank would benefit if we denied the Committee its right to full reimbursement, but all other plan members

> would bear the cost in the form of higher premiums. Reimbursement and subrogation provisions are crucial to the financial viability of self-funded ERISA plans, and, as a fiduciary, the Committee must "preserve assets to satisfy future, as well as present claims," and must "take impartial account of the interests of all beneficiaries." *Varity Corp. v. Howe*, 516 U.S. 489, 514 (1996).

Shank, 500 F.3d at 838; *see also Zurich Am. Ins. Co. v. O'Hara*, 604 F.3d 1232, 1237 (11th Cir. 2010); *Paris v. Iron Workers Trust Fund*, 211 F.3d 1265 (table) *3 (4th Cir. 2000); *Harris v. Harvard Pilgrim Health Care, Inc.*, 208 F.3d 274, 280-81 (1st Cir. 2000).

The facts presented in this case illustrate the effects of a double recovery on a single beneficiary at the expense of all other participants and beneficiaries in a plan. Petitioner recovered $500,000 from the responsible tortfeasor and the National Elevator Industry Health Benefit Plan ("Plan") claimed an equitable right to a share of that recovery in the amount of $121,044.02—the amount the Plan had already paid for Petitioner's medical expenses caused by the accident. Neither Petitioner nor its amici dispute that for the period of time that Mr. Montanile held the settlement funds, the Plan had an equitable lien on the portion of those funds it had advanced to Mr. Montanile. Nor do Petitioner or amici dispute that during this time, he held property that belonged to the Plan. Under the Plan's Declaration of Trust and under ERISA itself, plan assets are to be used solely for providing covered services to the Plan's participants and beneficiaries. *See* Appellant's Appendix Vol. I at 146, *Board of Trustees of the Nat'l Elevator Indus. Health Benefit Plan v. Montanile*, 593 F. App'x

903 (11th Cir. 2014) (No. 14-11678) (Restated Agreement and Declaration of Trust of the National Elevator Industry Welfare Plan Art. II, Par. 3); ERISA § 404(a)(1)(A). A single Plan participant should not be able to divert these funds for his exclusive use.

Petitioner notes that the fund subject to the Plan's lien was used to support Mr. Montanile's daughter and to maintain their home. Pet'r. Br. at 5. Petitioner also notes that the Plan has approximately $1 billion in assets and more than 500 participating employers. Pet'r. Br. at 4 n.1. While one may be sympathetic to Mr. Montanile's plight, it should also be noted that the Plan provides health benefits to over 31,000 active participants and retirees, plus tens of thousands of their dependents. The Plan paid well over $470 million in total benefit payments in 2013, the most recent year for which its tax filing is available.[2]

If the Plan were able to enforce its equitable right to reimbursement from the settlement proceeds, it could use that recovery to provide significant benefits to other participants and beneficiaries. For example, the Center

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[2] National Elevator Industry Health Benefit Plan, 2013 Form 5500 Annual Return/Report of Employee Benefit Plan at pt. II(5), Sched. H pt. II(2)(e)(4) (filed with the Dep't of Labor on Oct. 9, 2014), *available at* https://www.efast.dol.gov/portal/app/login?execution=e1s1. While the NCCMP represents the interests of large health funds like the Plan, it also represents the interests of plans that may have as little as $2 million in plan assets. If the judgment below is not affirmed, a small, seemingly well-funded multiemployer health benefit plan that has been providing benefits to a few hundred employees and dependents for decades could be rendered insolvent by one participant's successful effort to evade that plan's equitable lien by agreement by dissipating the fund subject to the lien.

for Disease Control estimates that $121,044.02 would cover the cost of all required immunizations for 115 children from birth up to age eighteen. *See Vaccines for Children Program: CDC Vaccine Price List*, Ctrs. for Disease Control & Prevention, *available at* http://www.cdc.gov/vaccines/programs/vfc/awardees/vaccine-management/price-list/ (last updated Aug. 3, 2015). Other multiemployer plans that are constituent members of NCCMP estimate that $121,044.02 would allow them to cover any of the following: annual prescription costs for thirteen cancer patients; seventy hearing aids; one month's prescription costs for 388 retirees and their eligible family members; over 1,700 speech therapy sessions; or pre-implantation treatment, entire hospital admission, and surgeon's transplant charges for one kidney transplant patient.

The disregard for plan terms urged by Petitioner would be particularly devastating to multiemployer plans' ability to provide these benefits. The reason that subrogation and reimbursement provisions serve such an important role in multiemployer plan design is in large part due to the manner in which these plans are funded. Multiemployer plans are established and funded through the collective bargaining process—once every three years or more the bargaining parties sit down to determine how much money will be directed to a self-funded multiemployer health plan over the duration of a collective bargaining agreement. With their sources of funding established through the collective bargaining process, self-funded multiemployer plans typically cannot raise employee premiums to offset increased costs of plan administration.

While funding through the collective bargaining process places limits on the assets available to self-funded multiemployer health plans, federal regulation of group health plans over the past thirty years has placed an increasing number of mandates on the rights and benefits these plans must provide. Beginning in 1986, when Congress first required plans to provide continuation coverage to employees and beneficiaries in the event of termination or other qualifying events, Congress, the Department of Labor, the Internal Revenue Service, and the Department of Health and Human Services have steadily increased the number of mandated benefits required of self-funded health plans. ERISA, as amended through 2009, now requires plans to provide continuation coverage to employees on qualified family or medical leave, to honor qualified medical child support orders, to provide reconstructive surgery following a covered mastectomy, to limit restrictions on benefits for preexisting conditions, to eliminate limits on hospital length of stays connected with childbirth, and to establish parity between mental health and substance abuse benefits and medical benefits.[3] And the

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[3] *See* Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. No. 99-272, 100 Stat. 82 (1986); Family and Medical Leave Act of 1993 (FMLA), Pub. L. No. 103-3, 107 Stat. 6 (1993); Child Support Performance and Incentive Act of 1998, Pub. L. No. 105-200, 112 Stat. 645 (1998); Women's Health and Cancer Rights Act, Pub. L. No. 105-277, tit. IX, 112 Stat. 2681-436 (1998); Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936; *Standards for Privacy of Individually Identifiable Health Information*, 65 Fed. Reg. 82,462 (Dec. 28, 2000) (codified at 45 C.F.R. pts 160 and 164); Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), Pub. L. No. 104-204, tit. VI, 110 Stat. 2935 (1996); Mental Health Parity Act of 1996 (MHPA), Pub. L. No. 104-204, tit. VII, 110 Stat.

impact of the foregoing requirements pales in comparison to that of the Patient Protection and Affordable Care Act ("ACA"). Pub. L. No. 111-148, 124 Stat. 119 (2010). Among other things, the ACA requires group health plans (including self-funded health plans) to eliminate lifetime and annual benefit limits for essential benefits, to provide dependent coverage for adult children up to age 26, to eliminate cost-sharing for preventive services and immunizations, to limit rescissions in eligibility to cases of fraud and intentional misrepresentation, to eliminate any pre-existing condition exclusions, and to eliminate waiting periods in excess of 90 days.

More than ever, trustees of multiemployer health plans must wrestle with escalating health care costs, including the costs of complying with new, expensive ACA minimum coverage requirements, at a time when many of those sectors of the economy where employees and their dependents are most likely to receive healthcare benefits through multiemployer plans are either in decline or are still recovering from the nation's worst recession since the Great Depression. With rising costs and few options for increasing funding, multiemployer plans must be able to rely on the enforceability of the subrogation and reimbursement provisions written into plan documents.[4]

2944 (1996); Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Pub. L. No. 110-343, tit. V.B, 122 Stat. 3881 (2008). This is not an exhaustive list, but it does include the more burdensome changes in the law since ERISA's enactment.

[4] Petitioner's suggestions that the summary plan description ("SPD"), which contains the reimbursement and subrogation provision in this case, does not constitute a "plan document" and

Preserving the link between effective enforcement of reimbursement and subrogation provisions and preservation of plan assets for present and future claims is critical to the self-funded multiemployer plans that are among the NCCMP's constituents. Such plans must ensure that contributions paid in accordance with the terms of collective bargaining agreements are sufficient to cover the costs of providing benefits. Although the vigorous efforts of trustees of such plans to enforce reimbursement and subrogation provisions may appear harsh when viewed from the perspective of a severely injured participant or beneficiary, in fact, the trustees are fulfilling their fiduciary duty to ensure that the plan may continue to provide benefits to all participants and beneficiaries. *See* ERISA § 404(a)(1)(A), ("a fiduciary shall discharge his duties with respect to a plan solely in the interest of participants and beneficiaries . . and for the exclusive purpose of . providing benefits to participants and their beneficiaries; and defraying reasonable expenses of administering the plan.").

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does not set forth the terms of the plan must be rejected. Pet'r Br. at 7 n.6, 8-11, 40 n.22. First, Petitioner expressly waived that argument before this Court. *Id.* at 13 n.8. Second, this Court has recognized that enforceable plan terms may be found in more than one document, *see Curtiss-Wright Corp.*, 514 U.S. at 83, and that an SPD may be enforceable under Section 502 of ERISA if it does not conflict with terms specified in other, governing plan documents, *see CIGNA Corp. v. Amara*, 563 U.S. 421 (2011). Finally, at least three circuits have reviewed the same SPD at issue here and have recognized that it functions as the controlling ERISA plan in the absence of a separate plan document. *See Bd. of Trs. of the Nat'l Elevator Indus. Health Ben. Plan v. Moore*, — F.3d —, No. 14-4048, 2015 WL 5010985, at *4-6 (6th Cir. Aug. 25, 2015) (collecting cases).

B. The Decision Below Protects Beneficiaries' Ability to Obtain Immediate Medical Benefits when Injuries are Caused by Third Parties.

Self-funded multiemployer benefit plans are not obligated by any law to pay medical benefits when a participant or beneficiary is injured by a third party. The result of the position advanced by Petitioners, for the Court to sharply constrict benefit plans' ability to enforce equitable claims over a portion of compensation received by tort victims, is that beneficiaries will be left with no medical coverage when they need it most, after an unexpected accident caused by a tortfeasor.

Although ERISA establishes a comprehensive regulatory scheme for benefit plans in general, it does not mandate any minimum substantive content for welfare benefit plans in particular. *See, e.g., Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983); *Hamilton v. Air Jam., Ltd.*, 945 F.2d 74, 78 (3d Cir. 1991). As a result, employers "have large leeway to design disability and other welfare plans as they see fit." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003). In *Metropolitan Life Insurance Company v. Massachusetts*, the Court held that ERISA "does not regulate the substantive content of welfare-benefit plans." 471 U.S. 724, 732 (1985). ERISA generally leaves it to plan sponsors "to adopt, modify, or terminate welfare plans." *Curtiss-Wright Corp.*, 514 U.S. at 78; *see Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981).

The vast majority of multiemployer plans affiliated with the NCCMP have not agreed to pay medical benefits for injuries caused by third parties. The written plans commonly provide that benefits are not payable

if a sickness or injury is the responsibility of a third party. However, recognizing that beneficiaries need to pay for extraordinary medical expenses in the event of unexpected illness or injury, plans allow for the advancement of benefits. That advance, however, is commonly conditioned on the beneficiary's promise to honor the benefit plan's equitable right to a portion of compensation if and when the beneficiary obtains a recovery from the responsible third party. *See, e.g., Kress v. Food Emp'rs Labor Relations Ass'n*, 391 F.3d 563, 565 (4th Cir. 2004) (involving plan's refusal to pay benefits for injuries from auto accident when beneficiary refused to acknowledge equitable reimbursement right); *Copeland Oaks v. Haupt*, 209 F.3d 811, 812 (6th Cir. 2000) (same); *Cagle v. Bruner*, 112 F.3d 1510, 1513 (11th Cir. 1997) (same).

The terms of a typical plan of benefits are illustrated by the plan considered by the Fourth Circuit in *Kress*:

> Waiting for a third party to pay for these injuries may be difficult. Recovery from a third party can take a long time (you may have to go to court), and your creditors will not wait patiently. Because of this, as a service to you, the Fund will pay your (or your eligible dependent's) expenses based on the understanding that you are required to reimburse the Fund in full from any recovery you or your eligible dependent may receive, no matter how it is characterized. This process is called "subrogation." .... The Fund extends benefits to you and your dependents only as a service to you. The Fund must be reimbursed if you obtain any recovery from another person or entity's insurance coverage.

391 F.3d at 566. Thus, far from having contracted to

bear the risk associated with the costs of injuries caused by third parties, benefit plans typically expressly disavow any obligation to pay benefits under those circumstances.

However, recognizing the difficult circumstances presented to beneficiaries, benefit plans typically agree to advance medical costs to tide over a beneficiary in difficult times, *but only if* the beneficiary promises to reimburse the benefit plan later. As emphasized by the Fourth Circuit, these plan provisions

> broadened rather than narrowed the options of Fund participants. Nothing required [the beneficiary] to accept the subrogation option; he was free to reject it and commence litigation at once, with no obligations whatever to the Fund. But if he did accept the Fund's offer, and then recovered in tort, it was not wrongful for the Fund to seek to recoup this expenditure to provide for future participants who may find themselves in similarly straitened circumstances. The Fund "must serve the best interests of all Plan beneficiaries, not just the best interest of one potential beneficiary."

Id. at 570-71 (footnote omitted) (citing *Ellis v. Metro. Life Ins. Co.*, 126 F.3d 228, 234 (4th Cir. 1997)). It is the voluntary nature of these advanced payments that clearly establishes the need for an *equitable* remedy of reimbursement as opposed to the legal remedy of a breach of contract.[5]

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[5] Petitioner's amicus, the American Association for Justice, argues that subrogation and reimbursement provisions constitute "illusive" coverage unfair to beneficiaries, and that restricting benefit plans' ability to enforce such provisions is appropriate

If the Court restricts benefit plans' ability to obtain equitable liens by agreement under these circumstances, as argued by Petitioner, the result will not be a greater recovery by beneficiaries in personal injury lawsuits. Instead, benefit plans will respond by simply not advancing these payments in the first place, leaving beneficiaries to deal with medical bills, creditors, and delays on their own through the uncertain and lengthy process of personal injury lawsuits. This cannot be good public policy.

Reducing benefit plans' equitable remedies, as urged by Petitioner, will create hardship for beneficiaries in another form as well. Currently, as described above, plans typically advance benefits to beneficiaries in their times of need, based on a promise to reimburse in the event that a future recovery is obtained. In some cases, at a point in time far in the future, the beneficiary may eventually recover a payment from the tortfeasor and be required to reimburse the plan. However, far more commonly, the beneficiary decides not to pursue an action against the responsible tortfeasor, or, based on the uncertainties and expense of litigation, agrees to a settlement for less than full compensation. In these common scenarios, the beneficiary will retain the benefit of having had medical expenses paid on his or her behalf

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because beneficiaries are merely receiving the benefits to which they are contractually entitled in the first place. Br. for Am. Ass'n for Justice as Amicus Curiae at 28. Thus, according to Amicus, because participants "have paid for" coverage, there is no policy justification to require beneficiaries to reimburse medical plans out of tort recoveries from third parties. *Id.* As detailed by the plan language quoted above, this argument ignores that many benefit plans do not, in fact, contract to bear the risk to pay medical benefits when injuries or sicknesses are caused by a third party.

without having to engage in legal action and without any obligation to reimburse the plan (beyond any amount recovered). This benefit will be lost to beneficiaries if plans stop advancing benefits in exchange for the right to an equitable claim of reimbursement.

C. Preserving a Meaningful Equitable Remedy in the Face of Dissipation is Necessary in Many Subrogation and Reimbursement Cases and in Other Types of Plan Recoveries as Well.

Petitioner claims that dissipation's destruction of a plan's equitable lien by agreement will occur in only a small fraction of cases where recoupment of benefits is sought – those "truly exceptional cases" where "the participant uses the settlement funds to purchase services (*e.g.*, childcare) or consumable goods (*e.g.*, food) from a bona fide purchaser for value." Pet'r Br. at 44-45. Petitioner contrasts such a situation with scenarios in which it claims funds can be traced and recouped by the plan, such as where a participant uses funds to obtain an asset, gives the funds to another person, or uses the funds to obtain goods or services from another person with notice of the lien. Pet'r Br. at 44.

The NCCMP disagrees that dissipation cases like Mr. Montanile's are "truly exceptional." If a participant could claim that a plan's equitable lien is destroyed to the extent that the participant paid his or her bills or purchased groceries after taking possession of settlement funds or other funds subject to an equitable lien by agreement, practically all participants who receive such funds would be able to void those liens to the detriment of their plans and their fellow participants. In a situation like *Montanile*, where a participant is in-

jured, it is even more likely that he or she will be able to claim dissipation of funds shortly after they are received because the participant most likely would have been unable to work while injured and may have accrued significant financial obligations during that time.[6]

Moreover, dissipation and destruction of plans' equitable liens by agreement will affect not only health and welfare plans but also all other types of plans, including pension plans. Petitioner and its amici acknowledge this fact. *See* Pet'r Br. at 21; Br. for AARP as Amicus Curiae at 3; Br. for Am. Ass'n for Justice as Amicus Curiae at 1. Indeed, AARP's entire amicus brief is devoted to the issue of overpayments in the pension plan context.

Overpayments from pension plans may result from a number of factual scenarios. For example, plans, which rely on participants and beneficiaries to alert them to life changes that affect benefits, may continue to make erroneous automatic benefit payments even though a participant has died if the plan is not alerted in a timely manner of the death. Benefits may also be obtained through fraud or as the result of miscalculations or ac-

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[6] Petitioner claims to have found "no evidence of a 'dissipation explosion'" in the jurisdictions that have adopted his position. Pet'r Br. at 42 n.23. This observation ignores the fact that such evidence would not be readily apparent since plans would be unlikely to bring claims against participants who have claimed dissipation in light of the Eighth and Ninth Circuits' decisions in *Treasurer, Trs. of Drury Indus., Inc. Health Care Plan & Tr. v. Goding*, 692 F.3d 888 (8th Cir. 2012), and *Bilyeu v. Morgan Stanley Long Term Disability Plan*, 683 F.3d 1083 (9th Cir. 2012).

cidental payment of a benefit to the wrong person. In all of these scenarios – some of which may not be discovered for some time – the plan must be able to enforce its terms to recover overpayments, whether or not the recipient has spent the overpaid funds on goods or services.

Kroop v. Rivlin, Case 04 Civ. 1401, 2004 WL 2181110 (S.D.N.Y. Sept. 27, 2004), illustrates the consequences of adopting Petitioner's position. In *Kroop*, the court found that a pension plan had no right to recoupment where a pensioner's son misrepresented that his father was alive for eight years while cashing his father's pension checks. The court ruled that, because the pensioner's son had spent the proceeds of the checks he had fraudulently cashed and no longer had possession of those funds, under *Great-West*, the plan's recoupment efforts were legal and not equitable and, therefore, relief was unavailable under ERISA. *Id.* at *2. Since *Sereboff*, Courts of Appeals have avoided the result of *Kroop* by holding that a plan's equitable lien by agreement attaches when funds are received and that subsequent dissipation is irrelevant. *See Elem*, 767 F.3d at 1198-99 (collecting cases). If these cases are overruled and Petitioner's position prevails, plans will have no right to recover funds paid to ineligible parties simply because the recipient of the funds spent them on normal costs of daily life.[7]

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[7] *Kroop* also illustrates the limits of Petitioner's assertion that a plan can recover amounts due to it from a beneficiary by simply deducting those amounts from that beneficiary's future plan payments. *See* Pet'r Br. at 21-22. In *Kroop*, or any other case where

Plan terms, especially in the pension context, are of paramount importance in promoting ERISA's principal goal of "protect[ing] contractually defined benefits." *Mass. Mut. Life Ins. Co.*, 473 U.S. at 148. In its amicus brief, AARP advocates for the interests of the few overpaid pension plan participants, but all plan participants suffer when plans do not have a full complement of tools to recoup overpayments.

In the context of a defined benefit pension plan–a plan that consists of a general pool of assets and gives each eligible participant the right to a certain level of accrued benefits, usually a fixed periodic payment commencing at normal retirement age–the plan must ensure that benefits are fully funded according to complex actuarial calculations. If terms are effectively added to the plan, as they would be if certain participants were allowed to keep erroneously paid benefits over and above their entitlement under the plan, the actuarial soundness of the plan may be jeopardized to the detriment of all participants. *See Shields v. Local 705, Int'l Bhd. of Teamsters Pension Plan*, 188 F.3d 895, 905 (7th Cir. 1999) (Posner, C.J., concurring) ("If terms are added . that appear nowhere in the plan documents upon which the actuarial calculations are based, that the actuaries who designed the funding mechanism in the plan did not know about . the plan may turn out to be seriously underfunded. [T]he actuarial impli-

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benefits are paid by the plan under circumstances where no entitlement to benefits existed, it would be impossible for the plan to recover them by offsetting future benefits. Of course, in health care cases, by definition, there is no possibility for a plan to offset future benefits because health benefits are paid only as needed for specified medical purposes.

cations are graver the more workers are involved. And it is particularly clear in a case . . . in which the defined-benefit plan is a multiemployer plan." (internal citations omitted)).

Similarly, in a defined contribution plan, contributions are paid into the plan and, upon retirement, each participant is entitled to the funds in his or her account. Under this plan design, an overpayment to one participant means that a participant who is paid more than the amount he or she has earned under the terms of the plan has been overpaid at the direct expense of another participant. The very narrow remedy of an equitable lien permitted by the court below is vital to benefit plans in any context in which recovery of plan assets is necessary.

II. BENEFIT PLANS DO NOT HAVE ALTERNATIVE UNIFORM OR ADEQUATE REMEDIES TO RECOVER MONEY IN EQUITY.

Petitioner and its amici suggest that benefit plans really do not need an equitable remedy under § 502(a)(3) of ERISA when the disputed funds have been spent because they have other adequate options to obtain the funds before they are dissipated. They argue that plans can largely protect their rights to reimbursement by intervening in state court lawsuits or by relying on participants' tort attorneys' ethical obligations to hold the funds until the ERISA plan has an opportunity to act. *See* Pet'r Br. at 42-43; Br. for United States as Amicus Curiae at 29-31; Br. for Am. Ass'n for Justice as Amicus Curiae at 24-26. These arguments should be rejected.

As an initial matter, the Petitioner's suggestion that benefit plans should intervene in state court lawsuits

ignores the fact that the vast majority of state court tort actions end in settlement. *See* U.S. Dep't of Justice, Bureau of Justice Statistics, NCJ 233094, *Punitive Damage Awards in State Courts, 2005* at 2 tbl.2 (Mar. 2011), *available at* http://bjs.gov/content/pub/pdf/pdasc05.pdf. Therefore, there will usually not be a state court lawsuit in which to intervene in the first place.

Petitioner's suggestion that benefit plans have adequate remedies in various state court jurisdictions also contravenes Congress's explicit purpose to obtain uniformity for benefit plans when it enacted ERISA. The purpose of the Act was to provide plans a uniform set of administrative procedures, rather than making them comply with a different set of procedures for processing claims and disbursing benefits in each state. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987); *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656-57 (1995) (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)). When applying this Congressional purpose to subrogation and reimbursement provisions in particular, this Court held that the "[a]pplication of differing state subrogation laws to plans would therefore frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide." *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990); *see also* ERISA § 514, 29 U.S.C. § 1144 (establishing the preemption of state laws that relate to ERISA benefit plans).

Intervention in state court tort lawsuits does not present a uniform set of procedures to address benefit plans' equitable rights of reimbursement and subrogation. If a beneficiary's tort action is pending, and as-

suming that the benefit plan is even aware of the lawsuit, benefit plans will be required to become experts in the intricacies of each state's tort recovery laws. They also will be required to monitor each jurisdiction's peculiar court rules and to hire local attorneys to protect the plans' interests. In addition, these state court actions will be located in any jurisdiction in which a benefit plan's beneficiary might travel or reside. As such, the need to defend the benefit plan's interests in far-flung jurisdictions will increase the plan's administrative expenses. In creating a federal remedy exactly for these situations, Congress was careful to craft a provision that allows benefit plans to sue in a convenient forum to preserve plan assets. *See* ERISA § 502(e)(2), 29 U.S.C. § 1132(e)(2) (providing an action may be brought in the district where the plan is administered). The result of losing a uniform equitable remedy in the federal courts will be increased administrative costs to these benefit plans and a concomitant reduction in benefits for the plans' participants and beneficiaries.

Petitioner next suggests that ERISA plans may rely on attorney rules of professional conduct, which caution personal injury attorneys not to disburse third party recoveries when the funds are subject to dispute, to protect benefit funds from dissipation. See Pet'r Br. at 42. Attorney ethical obligations, however, cannot substitute for enforcement of a plan's recovery rights. First, ERISA plans may not be aware of a recovery and thus will be unable to notify the beneficiary's counsel that a portion of the recovery belongs to the plan. Second, like tort actions, professional rules of responsibility vary from state to state, and multiemployer ERISA plans can ill-afford to divert scarce resources to becoming expert in the professional obligations of each

state's personal injury plaintiffs' bar. Moreover, even if a plan took action against the attorney for ethical violations, it would not be made whole. Discipline of lawyers for violations of their ethical obligations typically takes the form of admonition, censure, suspension of practice, or disbarment, not recoupment of funds owed to the plan.

Finally, even if a plan could show that a beneficiary's personal injury attorney improperly disbursed a plan's share of recovery from a tortfeasor, the plan has no cause of action (aside from § 502(a)(3)) against the attorney unless the attorney is a party to the subrogation agreement. *See Goding*, 692 F.3d at 894-95 (finding no implied contract between attorney and plan to honor plan's subrogation agreement unless the attorney signs the agreement); *AC Hous. Lumber Co. Emp. Health Plan v. Berg*, 407 F. App'x 208, 209 (9th Cir. 2010) (same); *Hotel Emps. & Rest. Emps. Int'l Union Welfare Fund v. Gentner*, 50 F.3d 719, 720-21 (9th Cir. 1995) (same).

The Circuit split on the issue presently before the Court clearly illustrates that beneficiaries who have received payments from the responsible tortfeasors and their attorneys often do not act in good faith with regard to their obligations. In no fewer than four cases regarding dissipation of settlement proceeds—not including the decision below—the beneficiaries and their attorneys worked together to defeat plans' equitable rights by dissipating or disbursing assets. *See Elem*, 767 F.3d at 1195 (beneficiary and her attorney "conspired to hide and disburse settlement funds she received" to avoid reimbursing welfare plan); *Cent. States, S.E. and S.W. Areas Health & Welfare Fund v.*

Lewis, 745 F.3d 283, 284-85 (7th Cir. 2014) (beneficiary's attorney refused to release any settlement proceeds to welfare plan, even after court order to do so, resulting in contempt finding); *Goding*, 692 F.3d at 892 (beneficiary's personal injury attorney twice acknowledged plan's reimbursement provisions, but disbursed all proceeds within a month after settlement); *Longaberger Co. v. Kolt*, 586 F.3d 459, 462 (6th Cir. 2009) (although plan had advanced beneficiary over $113,000 in medical fees and beneficiary's personal injury attorney knew of plan's reimbursement provision, attorney disbursed all but $1,000 in settlement funds). *See also Moore*, 2015 WL 5010985 at *2 (describing the lengths to which a beneficiary's attorney sought to shut out the plan from any and all rights to settlement proceeds). In these situations, which unfortunately occur more frequently than the Petitioner believes, a uniform equitable remedy is required to enforce the terms of the plan.

III. THERE ARE NO "COMPETING GOALS" UNDER ERISA THAT WOULD BE SERVED BY REVERSING THE DECISION OF THE LOWER COURT.

Petitioner and its amici assert that further reducing plans' equitable remedies under § 502(a)(3) would properly provide "balance between the competing goals of ERISA." Pet'r Br. at 16, 18, 21-22; *see also* United Policyholders Br. as Amicus Curiae at 16-17. But there are no policy goals in the statute that would reach the result sought by Petitioner: allowing one participant to violate the terms of the plan to create a windfall for himself at the expense of all other participants and beneficiaries in

the plan.[8] To the contrary, ERISA fiduciaries, such as the trustees of multiemployer plans, have a "duty to all beneficiaries to preserve limited plan assets" and "prevent . . . windfalls for particular employees." *Conkright v. Frommert*, 559 U.S. 506, 520 (2010). In fact, allowing multiemployer plans to enforce equitable liens by agreement set forth in plan terms honors the fundamental goals of ERISA: to protect contractually defined benefits for *all* participants and beneficiaries, *see Mass. Mut. Life Ins. Co.*, 473 U.S. at 142, to enable plans to be administered according to a uniform regime, *see Conkright*, 559 U.S. at 517, and to preserve assets to satisfy future, as well as present claims, *see Varity*, 516 U.S. at 514.

Far from advancing any of the interests identified by the Court, the Petitioner's proposed rule cuts against all of them. Petitioner's rule advances the interests of single plan participants over all others and thereby threatens plans' ability to provide benefits for all participants and beneficiaries. *See Mass. Mut. Life Ins. Co.*, 473 U.S.

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[8] Petitioner cites *Mertens* for balancing ERISA's "competing goals" to benefit employees on the one hand, and contain pension costs on the other. Pet'r. Br. at 18, 22 (citing *Mertens*, 508 U.S. at 263). However, the Court's discussion of containing pension costs in *Mertens* had to do with the possibility that these costs would increase if pension plans' non-fiduciary service providers were liable for all direct and consequential damages suffered by the plan. *See Mertens* at 262-63. Here, as explained at Section II, *supra*, the costs of plan administration will increase if plans are required to make herculean efforts to recover funds that they are now able to recover through equitable liens by agreement. Therefore, if anything, the Court's observations about ERISA's competing goals and its recognition of the nexus between the costs of plan administration and plans' ability to provide benefits in *Mertens* support the Respondent's position and not Petitioner's.

at 142. Moreover, by allowing a broad loophole for participants subject to equitable liens by agreement who are able to claim dissipation, Petitioner's rule destroys uniform enforcement of plans' reimbursement provisions. *See Conkright*, 559 U.S. at 517. Finally, Petitioner's position threatens the ability of plans to satisfy future claims by creating an avenue for participants to keep funds to which they lost entitlement or were never entitled to have. *See Varity*, 516 U.S. at 514.

At its core, the Petitioner and its amicis' objections to benefit plans' equitable reimbursement remedies are based on a perception that such a remedy is harsh and unfair. This overlooks the "commonplace economic calculus" present in every personal injury lawsuit. *Kress*, 391 F.3d at 570. According to the Fourth Circuit:

> Attorneys considering taking a case on contingency commonly factor the likelihood of success and the magnitude of recovery into their decision. "Many tort claims involve considerable risk and insufficient reward. Attorneys, however, carefully screen these claims and reject a large portion, including most denominated as high risk." . . If the participant and his attorney conclude that private litigation will not produce a sufficient recovery to make the litigation worthwhile, they need not bring the case.

Id. (internal citation omitted.) Thus, harsh results are not caused by benefit plans enforcing a right to reimbursement and subrogation. Instead the "unfairness" is often an inherent part of the litigation process that has been described, in this context, as being "like a lottery ticket." *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1298 (7th Cir. 1993). In fact, far from creating

hardships, the availability of subrogation and reimbursement serves to shift the risk of an uncertain recovery onto the *benefit plan* and away from the beneficiary. *See id.* at 1297. This is because, by advancing medical benefits to a beneficiary in anticipation of a possible equitable claim to proceeds obtained in the future, the "lottery ticket" of uncertain payment for medical expenses is transferred from the beneficiary to the benefit plan. *Id.* at 1298. Where the tortfeasor subsequently gives the beneficiary money to cover expenses the plan has already paid, preserving a limited equitable remedy under § 502(a)(3) is the only outcome consistent with ERISA's text and purpose.

CONCLUSION

For the foregoing reasons, the NCCMP respectfully urges the Court to affirm the decision of the Court of Appeals.

Respectfully submitted,

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